TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, February 14, 1906.

The President, Dr. George Woolsey, in the Chair.

PYLORIC OBSTRUCTION.

Dr. Willy Meyer presented a man, 33 years old, who had been operated on in Berlin, in 1902, for benign stricture of the pylorus, the operation done being a gastroenterostomy, combined with an enteroenterostomy.

When the patient was admitted to the German Hospital, in October, 1905, he complained of symptoms which indicated that the pyloric obstruction had recurred. They were not urgent, however, and before reopening the abdomen it was decided to write to Berlin and learn exactly what had been done at the previous operation. While awaiting an answer, the patient's symptoms became more acute; he vomited more or less continuously, especially after taking food, and upon examination it was found that the vomitus contained material that had been acted upon in the jejunum. Lavage of the stomach was immediately begun, and in the meanwhile a letter was received from Berlin which contained the information that on November 24, 1902, the patient's abdomen had been opened for the relief of a benign obstruction of the pylorus, and that at the time of the operation, which consisted of a combined anterior gastro- and enterostomy, gastric ulcerations were found which had extended into the head of the pancreas. A very long, irregularly-curved scar indicated the site of the previous operation.

On examination by Dr. Meyer a distinct splashing sound was made out, evidently within the stomach, and a second similar sound in the left inguinal region, and percussion produced a vermicular contraction of the intestine within. Upon exposing the stomach, by a straight abdominal incision, many adhesions were found as the result of the previous operation. After separating the omentum, it was observed that the efferent portion of the gut was tightly adherent to the abdominal parietes, and within its lumen a small foreign body could be felt. This subsequently proved to be a buried wire suture, the curved end of which was imbedded in the intestinal wall, which it had almost perforated. Upon investigation, it was found that the gastroentcrostomy opening had contracted, so that it would scarcely admit the tip of the small finger. The enterocntcrostomy had been done very close to the gastroenterostomy. The proximal loop, which had to pass across and over omentum and transverse colon, was long and hung loosely downward into the small pelvis. It was very much distended. From the pelvis it rose up perpendicularly to the stomach. This was probably the cause of the regurgitation of food from the jejunum into the stomach, as it followed the course of least resistance, the enteroenterostomy being placed so close to the stomach, that it could be but of little use.

After proper separation the gut was cut loose from the stomach, the hole in the latter closed by a double row of silk-sutures and that in the gut transversely, to avoid stricture. Before suturing the gut, the foreign body was extracted. Then a posterior gastroenterostomy of good length was done by the elastic ligature method, and the patient made a good recovery. He was entirely relieved of his symptoms, and had gained over thirty pounds in weight since the operation.

SPLENECTOMY FOR SARCOMA.

Dr. Willy Meyer presented a man of 30 who was referred to the surgical division of the German Hospital on account of the presence of a tumor of the spleen, which had grown rather rapidly, and showed signs of malignancy. It was easily palpable, and presented a nodular surface. There were no evidences of free fluid in the abdominal cavity, and yet the comparative

cachexia of the man made it probable that the growth was malignant in character.

Operation, December 18, 1905. After extirpating the umbilicus, the abdominal wall was freely incised, and a large quantity of serosanguinous fluid oozed out. Upon pushing aside the omentum, the spleen came into view. It was plainly the seat of a malignant growth, apparently secondary to embolic infection, although no other organ appeared to be involved. Upon attempting to remove the organ, dense adhesions to the omentum and diaphragm were met with, and in order to gain freer access to the vault of the latter, it was decided to make an osteoplastic flap of the costal arch. This was done by extending the incision upward, stripping off the thoracic muscles, then dividing the costal cartilages next to the sternum and ribs and turning up the flap. The field of operation was now in plain view, so that the adhesions in the vault of the diaphragm could be divided between two ligatures without any difficulty. After this it was found that the splenic tumor was adherent to the pancreas, and it was necessary to surround it with a ligature between the middle and proximal thirds, and remove a large section of it together with the spleen. The retro-peritoneal glands were also much infiltrated, and had to be removed.

After extirpation of the growth, the large cavity that remained was filled with sterile gauze. Mikulicz tampon. The man made a good recovery, and had enjoyed fair health since, although there were already evidences of further metastases in the abdomen. The growth proved to be a round-celled sarcoma. The infection had apparently been carried to the spleen from the retroperitoneal glands by way of the splenic artery, which later had become obliterated.

METHODS OF RADICAL CURE OF UMBILICAL AND VENTRAL HERNIÆ.

Dr. George Stewart read a paper with the above title.

Dr. Joseph A. Blake said he had operated on a number of cases of umbilical hernia, and five years ago at the Academy he had read a paper in favor of the overlapping method from side

to side. He would divide umbilical herniæ into two classes,—namely, those with diastasis of the recti muscles, and those in which this separation was absent. In the cases with diastasis in whom the abdominal parietes were much relaxed, he still favored the side-to-side overlapping method. He had operated on twenty-one cases by that method, eighteen for umbilical and postoperative ventral hernia with one small recurrence in a case of ventral hernia, and three for diastasis alone. In other cases, in which there was little or no diastasis of the recti muscles, he considered the overlapping method from above downward as preferable to the side-to-side plan, for the reason that it could be done more quickly and with less shock. This operation required a smaller incision than the other, and recovery from it was usually prompt. Furthermore, if it became necessary to sit the patients up in bed to relieve the breathing, the tension on the wound would also be relieved by the flexion of the body. In cases where the diastasis of the muscles was not pronounced, side-to-side overlapping would encroach on the intra-abdominal space too much, and interfere with breathing.

In his method of operating on these cases, Dr. Blake said, he simply overlapped the entire thickness of the abdominal wall (excepting the skin and subcutaneous fat) without any attempt to suture it layer by layer. One objection to the plastic operation was that the tissues were deprived of their nutrition, and one might as well use foreign material as autoplastic material that had been cut off from its nutrition. In the vertical overlapping operation the patients usually made a very smooth recovery. The transverse incision was carried to just inside the sheaths of the recti, then the recti were pulled aside a little, and the entire thickness of the abdominal wall was overlapped and sutured. No attempt was made to suture the peritoneum separately.

Dr. Willy Meyer said he had operated on these cases by both the vertical and transverse methods, and had also frequently resorted to heteroplasty, using the silver-wire filigree. He recalled one case in which he had employed the side-to-side overlapping method, which had impressed him with the fact that great care should be exercised in loosening the recti from their sheaths. The case was that of a very heavy woman, with a large ventral

hernia, and on attempting to bring the recti together, it was necessary to lossen them from their sheaths. A perfect cure resulted, but a year later the woman returned with a rather annoying hernia at the outer border of one rectal sheath, where the muscle had been loosened. There was no tissue with which this gap could be filled, and silver-wire netting was thereupon inserted, which resulted in a complete eure.

The speaker said that while the overlapping method of treating this condition was an excellent one, there were a certain number of cases, especially of recurrent abdominal herniæ, where it was not practicable on account of lack of material, and in such cases the use of silver wire or of wire filigree was necessary. A review of his records showed that he had done this kind of heteroplasty fifteen times on fourteen cases with 3 failures and twelve complete cures. The case where a second operation became necessary was that of a woman weighing 250 pounds, who had a very large ventral hernia, which was successfully closed with silver-wire filigree. Subsequently, she sustained an injury, and partial recurrence, and upon reopening the abdomen it was found that the intestines had escaped through a perforation in the wire netting. More of the silver wire was inserted, and there had been no further recurrence since the operation, which was done five years ago. The speaker said he had seen tremendous herniæ which there would have been no chance of curing without resorting to heteroplasty. He emphasized the fact that every kind of ventral hernia could be cured, either by the autoplastic methods, which were the best if they were feasible; if not, one should not hesitate to use the silver-wire filigree. A number of his cases in which he had employed the latter method remained absolutely cured after three years. Of course undisturbed, aseptic wound-healing was an absolute requirement of success.

Dr. Stewart, in closing, said that while the statement made by Dr. Blake that the tendons, deprived of their nutrition, were apparently foreign bodies, practically that did not seem to be the case. He had no explanation to offer as to what became of them, unless it was that they still retained their vascularity. Personally, Dr. Stewart said, he had had no experience with heteroplasty. While he believed there were cases in which it had to be resorted

to, he thought they were very few. It was in the very large herniæ especially that the abdominal wall was lengthened, and that overlapping was possible. The insertion of silver-wire filigree into the abdomen had in some instances given rise to trouble.

Dr. Stewart said he could not speak regarding the permanency of the cure in his cases, as they were all still comparatively recent.

CONGENITAL STENOSIS OF THE PYLORUS.

Dr. John Rogers showed a specimen removed from the body of a child born on November 13, 1905. There were no symptoms for several weeks after birth; then the usual signs of congenital pyloric stenosis developed, and an operation for its relief was done on January 27, 1906. The stomach had a capacity of about three ounces, and the pylorus was represented by a dense fibrous ring of pale color and feeling like cartilage and about the size of the end of the little finger, and was apparently completely closed. A posterior gastroenterostomy by the suture method was done, close to the duodenojejunal fold.

For the first week after the operation, the convalescence was apparently favorable. Then there was a rise of temperature, and upon inspection, a knuckle of intestine was found protruding from the abdominal wound. This was replaced, and the wound again sutured. Union again failed to occur and the child died a week later. At autopsy there was found a low grade of adhesive peritonitis binding together the coils of intestine around and to the margins of the wound (the silk stitches had "cut through"). There was no pus. The rest of the abdominal cavity was normal. The gastroenterostomy wound had united perfectly and the fistula would admit a No. 20 F. sound with ease. The stomach had contracted to a capacity of about half an ounce. The pylorus was about double the size which had been noted two weeks before at operation and was softer. The lumen was found to be patent and capable of admitting about a No. 15 F. sound. On cross section the pyloric wall was about ⅜ of an inch thick and this apparently consisted chiefly of œdematous muscle. The microscopic examination will be completed later and announced at another meeting. The remarkable fact about the specimen is

that the pylorus was closed at the time of operation and yet became patent within the next two weeks.

Dr Blake referred to a case of what appeared to be spasmodic stricture of the pylorus in a child five years old, in which the symptoms dated back three years. At times, no food would seem to be able to pass through the pylorus; at other times the child was comparatively free from trouble. A Finney operation was done, which relieved the symptoms. The pylorus was apparently hypertrophied.

MECKEL'S DIVERTICULUM FILLED WITH SEEDS.

Dr. George Woolsey showed a specimen, removed from a woman in the course of an operation for extirpation of the uterus and adnexa for malignant adenoma.

While inserting a pad into the abdomen, he came into contact with a pear-shaped body, about two and a-half inches long, which seemed to be filled with solid contents. To the touch, it resembled the gizzard of a chicken filled with small pebbles. It was located about eighteen inches from the cæcum, and proved to be a Meckel's diverticulum. It contained several hundreds of dark-colored small, round and oval bodies, most of which gave a facetted appearance. These were at first sight regarded as tiny gall-stones, so they were sent to the pathologists, who reported that some of them were grape-seeds, but that most of them were tomato-seeds with a number of raspberry and other seeds. The sac contained no fecal matter; nothing but these seeds.